59th Medical Wing

U.S. AIR FORCE

59 MDW Pediatrics Product Line Analysis Clinic Response

Information Brief

Briefer: Col Robert Ellis

Date: 15 October 2004

Overview

- 59 MDW/CC Follow-up Issues
  - From Step 1 Brief
- Basic CAMO Rules
  - Initial Clinic Business Rules
- Current/Future Problem Areas
- Support Requirements from 59 MDW/SA-MM

Follow-up from Step 1 Brief

59 MDW asked you to provide information and f/u on the following issues

- Why doesn't Army provide any support staff to go along with their pediatric subs?
  - According to COL Cieslak, staffing was negotiated with BAMC during integration planning a number of years ago
  - BAMC subspecialists were moved to WHMC with consolidation of pediatric inpatient services
  - Although WHMC had primary responsibility for pediatrics, BAMC had primary responsibilities in other areas
  - The contribution from each institution was felt to be equitable at the time of the integration

Follow-up from Step 1 Brief (con't)

59 MDW asked you to provide information and f/u on the following issues

- What is the "cost" in terms of travel that we may pay and more importantly in terms of lost workload of Peds "Outreach Clinics"?
  - FY04 expenses (per diem) to WHMC were approx $1000
  - Fund cites from all sites except Sheppard, Fort Polk and Dyess
  - Requiring funds cites from all supported MTFs in FY05
  - Accounts for 12% of subspecialty provider time or 3.2 FTEs
  - Access standards maintained for all subspecialties participating in outreach, so no loss of subspecialty patients to network

- Secondly, are these agreements formalized in MOUs?
  - No – No relevant MOUs identified

Follow-up from Step 1 Brief (con't)

59 MDW asked you to provide information and f/u on the following issues

- Have you submitted "additive workload of supporting outreach clinics to be factored into MAPPG06, etc.?
  - No – How do we submit a request?

Follow-up from Step 1 Brief (con't)

59 MDW asked you to provide information and f/u on the following issues

- Can we get GWOT to fund contract FTEs to backfill Deployed Army Providers?
  - FY04 funding for intensivist approved through BAMC, but not used as couldn't hire contractor
  - FY05 funding for intensivist applied for ($117K for a full time intensivist for 7 months) through BAMC
  - Funding for geneticist approved and used to hire full-time genetic counselor (physician geneticist not available)
  - Funding for two providers now moot as they have returned to CONUS
    - Adolescent medicine provider to be full-time at BAMC
    - Neonatologist to be at BAMC, Camp Bullis, and Ft Hood
  - Opportunities to request GWOT for:
    - Hematologist (and for 2nd hematologist in December)
    - Cardiologist (may deploy in February)

Follow-up from Step 1 Brief (con't)

59 MDW asked you to provide information and f/u on the following issues

- What's the LOE for NICU manning assistance in the last year or so (e.g. how many have you supported?)
  - Fort Hood – 1 week trips x 5
  - Naval Hospital Okinawa – 3 week trips x 2, 1 week trip x 1

- Who is making the request? Is it going through your commander?
  - Fort Hood – Request goes from Ft Hood through GPRMC with orders issued by BAMC (doesn't go through commander)
  - Okinawa – Orders issued by WHMC (TDY request approved by squadron commander)

Follow-up from Step 1 Brief (con't)

59 MDW asked you to provide information and f/u on the following issues

- Coodination of Okinawa manning assistance
  - Okinawa NH requests manning assistance through 18 MDG at Kadena
  - Request is submitted to PACAF SG
  - PACAF SG coordinates with USAF SG neonatology consultant to identify available neonatologist
  - PACAF SG issues fund cite and sends letter to AFPC requesting coordination with AETC
  - PACAF SG also sends fund cite to Okinawa NH
  - Okinawa NH sends fund cite to WHMC NICU
  - TDY request with fund cite submitted for orders

- FY05 NICU manning assistance projection
  - Okinawa – 2 or 3 trips of 1-3 weeks each
  - Fort Hood – 7 trips of 1 week each

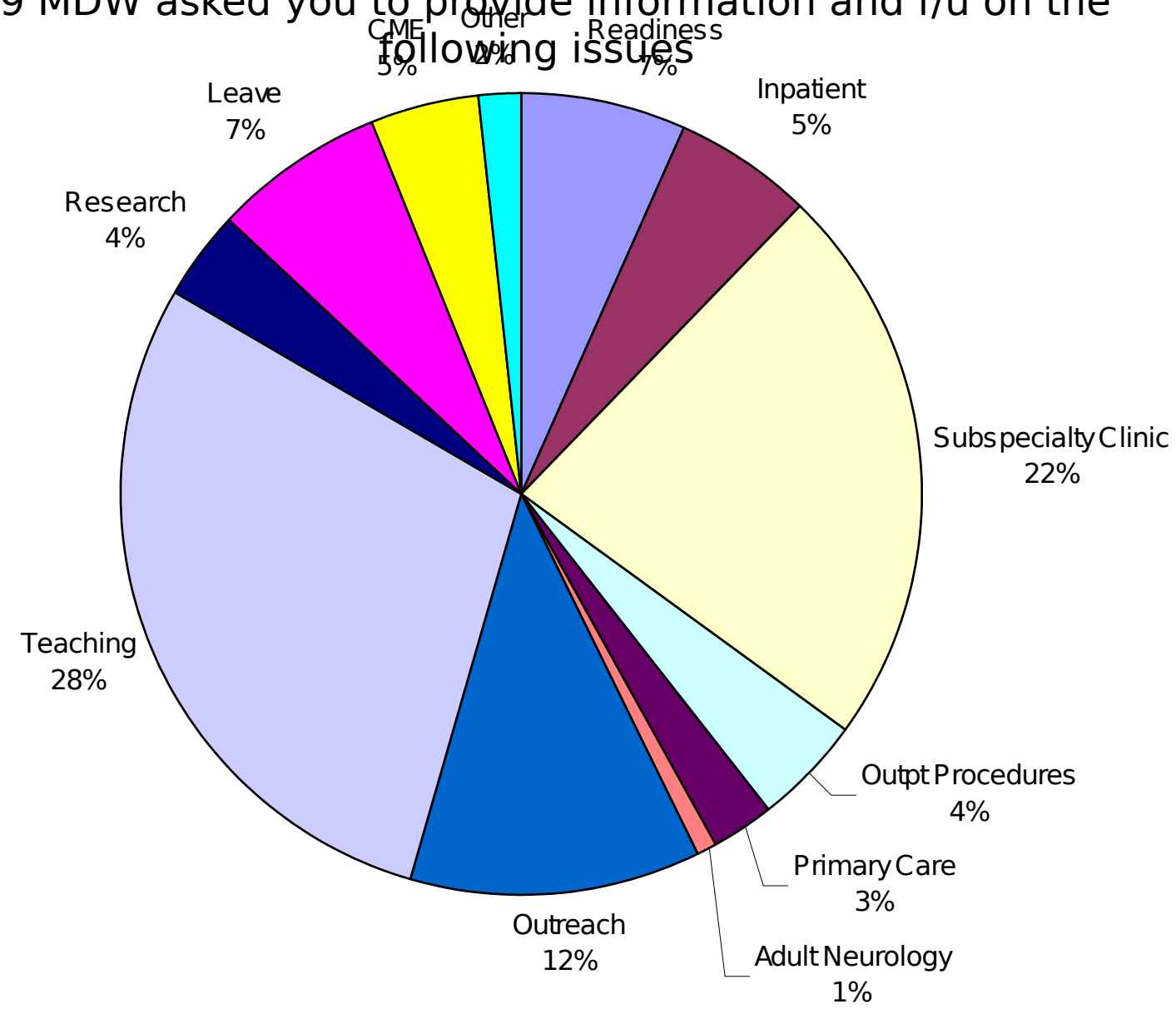
Follow-up from Step 1 Brief (con't)

59 MDW asked you to provide information and f/u on the following issues

- Show true number of appointments for Peds subs vs. what was pulled from CHCS
  - Previous briefing indicated that subspecialty productivity was 2.1 patients per provider per day

Follow-up from Step 1 Brief (con't)

59 MDW asked you to provide information and f/u on the following issues



Follow-up from Step 1 Brief (con't)

59 MDW asked you to provide information and f/u on the following issues

- Subspecialty productivity
  - Only 22% of provider time in clinic (=6.5 FTEs)
  - 13,717 specialty clinic encounters in FY04
  - 30% of encounters not captured in CHCS
    - Inpatient consults
    - Procedures without visits
    - Weekend and holiday encounters
    - Some walk-ins and T-cons missed
  - Actual encounters approximately 19,595
  - Actual productivity 12 patients/FTE/day

Follow-up from Step 1 Brief (con't)

59 MDW asked you to provide information and f/u on the following issues

- Discuss idea of giving immunizations in peds clinic
  - Currently immunization clinic visits are non-count
  - Workload for immunizations isn't apparent
  - Many MTFs have trained 4Ns to give immunizations in primary care clinics
  - Can be more convenient for patients (but immunization clinic is right across the hall, so not too relevant here)
  - Main advantage is increase in RVUs for clinic visits
  - Would generate fee for service revenue ($74/RVU)
  - Immunization administration has 0.21 RVUs for first shot and 0.14 RVUs for additional shots (CPT 90471 and 90472)
  - If we gave all recommended shots at well child visits (based on FY04 visits) revenue would be $335K
  - Would require 2.5 FTE techs, refrigerator, space

Initial Clinic Business Rules

- General pediatric and adolescent clinic
  - Appointments available only to patients enrolled to those clinics
- Subspecialty clinics
  - Appointments available to any dependent child beneficiary
  - Self referrals accepted (no consult or referral authorization from PCM required)
- Same day patients (if no appts available)
  - Primary care – offer WHMC ER/MCC, PCM telephone consult, or network provider
    - Optimally refer to triage nurse if position filled
  - Subspecialty clinic – contact physician on call for that subspecialty

Areas of Concern Current/Future Problem Areas

- Insufficient Personnel (#1 problem)
  - Providers
    - Critical care staff – contract providers pending credentialing
      - Risk closure of PICU if staff deploy (on CCATT team) and contract staff not available
    - General pediatricians – losing 3 FTE RSA positions
      - Losing 3 FTE RSA positions
      - 500 patients overenrolled by model
      - Discontinuing weekend/evening clinic
      - Expanding clinic hours to 0800 to 1800
      - Increasing appointments from 18 to 23 per staff provider/day
      - MAPPG 06 drops authorizations to 3 military gen peds

Areas of Concern
Current/Future Problem Areas

- Insufficient Personnel
  - Nurses
    - No nurses in primary care clinic
      - Unable to implement PCO
      - Desperately need triage nurse for demand management
    - Inpatient units (PICU, NICU, and ward) with reduced beds
      - Adversely affecting training programs
      - Critical to maintain 6-bed PICU
        - » Smaller unit insufficient to maintain nursing skills or to meet clinical demand

Areas of Concern Current/Future Problem Areas

- Insufficient Personnel
  - Techs
    - Bottleneck checking in patients in primary care
      - Max throughput 25 patients/hr (vs 41/hr needed with new schedule)
    - Provider efficiency greatly reduced
    - Losing contract audiology techs at end of month
      - Working to modify contract to retain position
      - Unsure how we can accomplish newborn hearing screens
    - RSA replacement contract for medical clerks still not awarded
      - Half of our 4A equivalent staff is currently Spectrum contractors
      - Will cripple clinic if not available 11/1/04

Areas of Concern
Current/Future Problem Areas

- Insufficient space
  - Primary care
    - Usually have 1 combination office/exam room per provider
      - Impairs efficiency – appointments every 20 minutes
      - Will have average of 2 exam rooms/provider with staggered schedules
    - Adolescent medicine needs separate clinic space to satisfy fellowship accreditation requirements
  - Inpatient ward
    - Temporarily moved to 8B during renovation
    - 18 beds, but some unusable due to cohorting issues
      - 4-bed rooms may not be filled due to infection control and patient gender issues
    - Physical capacity inadequate for usual high winter census

Areas of Concern
Current/Future Problem Areas

- Poor staff morale
  - Documented in unit climate survey
  - Excess workload is major contributing factor
    - Staff providers average 67 hours/week
    - Related to lack of support staff
  - Internal communication / teamwork also being addressed

Areas of Concern Current/Future Problem Areas

- Equipment
  - Pediatric clinic check-in area
    - Insufficient equipment to obtain vital signs, contributes to backlog and inefficiency
    - Need to process 7 patients simultaneously to allow 15 minute appointments
    - Additional vital sign monitors, scales, stadiometers needed (cost $13K)
  - Critical equipment approved but unfunded
    - ECMO machines, neonatal incubators
    - Current equipment at the end of useful life
  - Patient furniture falling apart – also approved/unfunded
    - Gives families immediate bad impression of facility

Areas of Concern
Current/Future Problem Areas

- Medical Records
  - Poor record availability at appointments
  - Coding issues
    - Many subspecialty visits not accounted for in CHCS / M2
    - Inaccurate coding for visits that are in system
      - Low average RVUs / encounter confirms inaccurate coding
      - Subspecialty consults routinely coded as established pt visits
      - Detailed coding audit needed

Support Requirements

- General pediatric clinic
  - Ensure medical clerk contract signed and clerks avail 11/1
  - Additional staff – 5 4Ns/LPNs, 2 4As/clerks, 1 RN
    - To establish PCE teams need 11 4N, 2 4A, 11 RN
  - Vital sign equipment - $13K funding
- Subspecialty clinic
  - Coding audit / process improvement
- NICU / Newborn
  - Fund ECMO equipment / incubators ($293K)
  - Ensure audiology tech retained (0.5 FTE)
- Ward
  - Fund furniture ($32K)
- Overall – Fix MAPPG 06 problems
  - Gen peds, PICU, endocrinology